

***Superseded 5/12/2015***

**63A-13-204 Selection and review of claims.**

- (1)
  - (a) The office shall periodically select and review a representative sample of claims submitted for reimbursement under the state Medicaid program to determine whether fraud, waste, or abuse occurred.
  - (b) The office shall limit its review for waste and abuse under Subsection (1)(a) to 36 months prior to the date of the inception of the investigation or 72 months if there is a credible allegation of fraud. In the event the office or the fraud unit determines that there is fraud as defined in Subsection 63A-13-102(5), then the statute of limitations defined in Subsection 26-20-15(1) shall apply.
- (2) The office may directly contact the recipient of record for a Medicaid reimbursed service to determine whether the service for which reimbursement was claimed was actually provided to the recipient of record.
- (3) The office shall generate statistics from the sample described in Subsection (1) to determine the type of fraud, waste, or abuse that is most advantageous to focus on in future audits or investigations.